

RULEMAKING NOTICE FORM

Notice Number 2009-53

Rule Number He-M 408

1. Agency Name & Address: Department of Health and Human Services Bureau of Behavioral Health Hugh J. Gallen State Office Park 109 Pleasant St, Main Building Concord, NH 03301	2. RSA Authority:	RSA 135-C:5, I, (e); 135-C:61, III
	3. Federal Authority:	N/A
	4. Type of Action:	
	Adoption	X
	Amendment	
	Repeal	
	Readoption	
	Readoption w/amendment	

5. Short Title: **CLINICAL RECORDS**

6. (a) Summary of what the rule says and the effect of the rule on those regulated:

These rules establish the required components of the clinical records maintained by community mental health programs and their subcontracted service providers for persons eligible to receive state-funded services pursuant to RSA 135-C:13 and He-M 401 and identify the contents of those components. Compared to the rules that expired in May 2008, records for children must now be retained for 7 years rather than 22 years beyond the age of 18. A requirement has been added regarding the professionals comprising an Individual Service Plan (ISP) team. Progress notes must specify the date, time, and duration of each service and, generally, be more detailed. Corrections to clinical documentation must be signed and dated. Notes must be written for each service provided pursuant to He-M 426 and for each face-to-face encounter. ISP reviews must occur quarterly for each client. Documentation must address the medical necessity of the service. References and terminology are updated to conform with recently amended statutes and rules. Further, some text has been reworded for clarity.

6. (b) Brief description of the groups affected:

Community mental health programs and their subcontracted service providers, and persons eligible to receive state-funded services pursuant to RSA 135-C:13 and He-M 401 and identify the contents of those components.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

Rule Number	RSA/Federal Citation
He-M 408.01 -408.15	RSA 135-C:5, I, (e); 135-C:61, III

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name:	Maya Blanchette	Title:	Rules Coordinator
Address:	DHHS/Office of Program Support Brown Building 129 Pleasant Street Concord, NH 03301	Phone #:	271-4190
		Fax#:	271-5590
		E-mail:	maya.blanchette@dhhs.state.nh.us

TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:

<http://www.dhhs.state.nh.us/DHHS/ADMINRULEMAKING/default.htm>

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Monday, May 11, 2009**

☒ Fax ☒ E-mail ☐ Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Friday, May 1, 2009, at 2:00 PM**

Place: **129 Pleasant St., Brown Building, Auditorium, Concord, NH 03301**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # **09:044**, dated **3/27/09**

Fiscal Impact Statement for Department of Health and Human Services rules governing Clinical Records.
[He-M 408]

1. Comparison of the costs of the proposed rule(s) to the existing rule(s):

The previous rules expired in May 2008. The Department has continued to operate under the provisions of the expired rules. There is no difference in costs when comparing the proposed rules to the expired rules.

2. Cite the Federal mandate. Identify the impact of state funds:

No federal mandate; no impact on state funds.

3. Cost and benefits of the proposed rule(s):

A. To State general or State special funds:

None.

B. To State citizens and political subdivisions:

None.

C. To Independently owned businesses:

None.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution: **The proposed rule does not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore does not violate Part I, Article 28-a of the N.H. Constitution.**

Adopt He-M 408, previously effective 5/23/00 (Document # 7281), and expired 5/23/08, to read as follows:

PART He-M 408 CLINICAL RECORDS

Statutory Authority: New Hampshire RSA 135-C:5, I, (e); 135-C:61, III

He-M 408.01 Purpose. These rules establish the required components of the clinical records maintained by community mental health programs and their subcontracted service providers for persons eligible to receive state-funded services pursuant to RSA 135-C:13 and He-M 401 and identify the contents of those components.

He-M 408.02 Definitions. The words and phrases used in these rules shall mean the following:

(a) "Case manager" means the person employed by the community mental health program who provides case management services in accordance with He-M 426.

(b) "Client" means any person eligible pursuant to RSA 135-C:13 and He-M 401 to receive state-funded services in the state mental health services system.

(c) "Clinical record" means the cumulative documents, collected and preserved, containing information relative to the care and treatment of each individual client.

(d) "Commissioner" means the commissioner of the department of health and human services.

(e) "Community mental health program (CMHP)" means a program operated by the state, city, town, or county, or a community-based New Hampshire nonprofit corporation for the purpose of planning, establishing, and administering an array of community-based, mental health services pursuant to He-M 403 and as defined in RSA 135-C:2, IV.

(f) "Facility" means New Hampshire hospital or a community receiving facility designated pursuant to RSA 135-C:26 and He-M 405, or an acute psychiatric residential treatment program pursuant to He-M 1005.

(g) "Credentials" means the abbreviation of one's academic degree and title as it pertains to the person's role in providing services to a client.

(h) "Family member" means the parent, foster parent, legal guardian, child, brother, sister, spouse, significant other, grandparent, grandchild, stepparent, aunt, uncle, or first cousin of the client.

(i) "Goals" means long-term, observable, desired accomplishments or changes to be achieved by a client.

(j) "Guardian" means a guardian, or a temporary guardian, of the person appointed pursuant to RSA 463 or RSA 464-A or the parent of a consumer under the age of 18 whose parental rights have not been terminated or limited by law.

(k) "Individual service plan (ISP)" means a written proposal that:

(1) Is developed annually as the result of a service planning process pursuant to He-M 401; and

(2) Includes the identification of:

a. The client's goals and objectives;

- b. The client's treatments and services;
- c. Timelines for achieving the stated goals; and
- d. Referrals to generic services when appropriate.

(l) "Licensed practitioner of the healing arts" means a person who meets the qualifications and provides psychotherapy or other services identified pursuant to He-M 426.

(m) "Mental illness" means a condition of a person who is determined severely mentally disabled in accordance with He-M 401 and who has at least one of the following psychiatric disorders classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV):

- (1) Schizophrenia and other psychotic disorders;
- (2) Mood disorders;
- (3) Borderline personality disorder;
- (4) Post traumatic stress disorder;
- (5) Obsessive compulsive disorder;
- (6) Eating disorder;
- (7) Dementia, where the psychiatric symptoms cause the functional impairments and one or more of the following co-morbid symptoms exist:
 - a. Anxiety;
 - b. Depression;
 - c. Delusions;
 - d. Hallucinations;
 - e. Paranoia; or
- (8) Panic disorder.

(n) "Objectives" means short-term, desired accomplishments designed to assist the client in achieving the long-term goals identified on the individual service plan.

(o) "Outcome measures" means the results of an evaluation that determines:

- (1) The residential environment within which the client is functioning;
- (2) The client's ability to perform vocational activities;
- (3) The client's ability to manage his or her psychiatric treatment, such as taking medications and making and keeping medical appointments; and
- (4) The degree of the client's substance abuse.

(p) "Psychiatric diagnosis" means a medical conclusion describing a person's mental health status developed and formulated in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

(q) "Rehabilitation" means the reinstatement of a former level of functioning or achieving a higher level of functioning than existed on admission to a program or residence through the provision of therapy, education and activities as specified in the individual service plan.

(r) "Residential program" means a non-facility based residence for the care and treatment of people with a mental illness.

(s) "Service planning process" means the annual review conducted with clients, providers and family, when appropriate, to develop or revise an individual service plan.

(t) "Suspension" means a time limited, specific withholding of any available service(s) from a client for well-defined and documented reasons and pursuant to He-M 401.

(u) "Termination" means the cessation for an indefinite period of all services to a client in accordance with He-M 401.

(v) "Treatment" means the examination, assessment, diagnosis, training, rehabilitation therapy, pharmaceuticals and other services provided to clients within the mental health service system, excluding examination or diagnosis for the purpose of determining the need for involuntary emergency admissions pursuant to RSA 135-C:27-33 or involuntary admissions pursuant to RSA 135-C:34-54.

(w) "Unit" means a period of time during which services are rendered.

He-M 408.03 Establishment of the Clinical Record.

(a) Each community mental health and residential program shall have a written clinical records policy that:

- (1) Outlines the content, maintenance, and monitoring requirements for its clinical records;
- (2) Addresses the completeness, accuracy, and timeliness of documentation;
- (3) Addresses confidentiality; and
- (4) Stipulates how and when clients may access their own records.

(b) Every client shall have a clinical record that meets the requirements of He-M 408 and the program's policy.

(c) The clinical record shall be:

- (1) Accessible to staff providing services;
- (2) Accessible to the client or the parent or guardian if the client is a minor or legally incompetent, unless otherwise prohibited by law; and
- (3) Available for supervisory and quality assurance activities conducted by the CMHP or the bureau of behavioral health.

(d) Information within the clinical record, including statistical data, shall be available for prompt retrieval in hard copy, as needed.

(e) All entries shall be signed and dated, as follows:

- (1) Each entry shall include the legible name, signature and credentials of the provider rendering services;
- (2) If the entry date is not the signature date, the signature shall also be dated;
- (3) Each delivery of service shall be dated; and
- (4) Each entry shall be made prior to the service being billed.

(f) The client or guardian shall document informed consent for all planned services except as otherwise prohibited by law or where emergency treatment is indicated pursuant to RSA 135:21-b.

(g) Clinical records shall be retained by a program or facility for 7 years after closure of a record for an adult and for 7 years beyond the age of 18 for a child.

(h) Subcontracted service providers shall comply with all the provisions of He-M 408.

He-M 408.04 Clinical Record Components.

(a) The clinical record shall be designed to:

- (1) Show the medical necessity for services provided;
- (2) Document the response to and effectiveness of services and interventions;
- (3) Document the extent of coordination of care by system-wide providers and, when appropriate, with providers outside the mental health system; and
- (4) Provide documentation substantiating the delivery and appropriateness of services as required by He-M 401 and He-M 426.

(b) The clinical record shall include, at a minimum, the following components:

- (1) Intake and assessment information in accordance with He-M 408.05 (a) and (b);
- (2) Demographic data in accordance with He-M 408.05 (c);
- (3) Annual notification of client rights in accordance with He-M 309;
- (4) Clinical data base in accordance with He-M 408.06 (b);
- (5) Documentation of eligibility determination in accordance with He-M 401;
- (6) Client service planning documentation pursuant to He-M 401;
- (7) Individual service plan;
- (8) Documentation of service delivery and outcomes;
- (9) Suspension, transfer, and discharge notes, if applicable;
- (10) Documentation of ISP reviews;

- (11) Physicians' orders, laboratory results and general health information;
- (12) Pertinent legal data;
- (13) Admission and discharge reports from mental health facilities and from other providers, when applicable; and
- (14) Case management care plan pursuant to He-M 426, when applicable.

He-M 408.05 Intake, Assessment, and Demographic Data.

(a) An application for services shall be completed and signed by the client or guardian at or before the intake interview.

(b) Documentation of the intake interview shall include:

- (1) The reason the client is requesting services;
- (2) The results of a preliminary clinical assessment including:
 - a. Presenting symptoms;
 - b. Diagnosis;
 - c. An assessment of the history and current risk of substance abuse; and
 - d. The results of a mental status examination.

(3) A preliminary list of services to be provided based on the client's stated goals and information gathered during the interview.

(c) As part of the intake process or before, the following demographic data shall be collected and documented:

- (1) Name, address and telephone number of the client or applicant;
- (2) Date of application for services;
- (3) Date of birth of the client or applicant;
- (4) Name, address, and telephone number of guardian if applicable;
- (5) Financial information including:
 - a. Insurance;
 - b. Private resources; and
 - c. Eligibility determinations for financial assistance from programs such as SSI, APTD, Medicare, Medicaid, and food stamps;
- (6) Next of kin;

- (7) Education;
- (8) Marital status;
- (9) Employment; and
- (10) Legal status.

(d) Demographic data shall be reviewed at least annually and kept current at all times.

(e) Demographic data shall be signed and dated by the person gathering the information.

He-M 408.06 Clinical Data Base.

(a) The clinical data base shall:

- (1) Be derived from information gathered during the intake assessment;
- (2) Include medical, psychiatric, and social information;
- (3) Include both historical and current information and assessments; and
- (4) Serve as a basis for ISP development.

(b) The components of a clinical data base shall include, at a minimum, the following.

(1) Medical information including:

- a. A statement of the person's general physical health status;
- b. Medical history; and
- c. When applicable, medical diagnosis and the results of any medical and neurological screenings, examinations and tests;

(2) Psychiatric information including:

- a. History of present illness including onset and severity;
- b. Previous services and treatments including medications and hospitalizations;
- c. Precipitating events for this episode;
- d. Coping strategies;
- e. Current diagnosis;
- f. Medical need for services;
- g. Physicians' orders;
- h. Results of laboratory testing, including tests for medication blood levels and for blood counts;
- i. Medications;

- j. Results of formalized psychiatric and/or psychological tests, if applicable;
- k. Mental status examination results; and
- l. Diagnostic formulation by a psychiatrist or other licensed practitioner of the healing arts under the auspices of a psychiatrist licensed to practice in the State of New Hampshire;

(3) Social information including:

- a. Developmental history, when relevant;
- b. Educational history;
- c. Familial history of mental illness and substance abuse;
- d. History of childhood abuse and neglect;
- e. Past and current use of chemicals and alcohol including illicit drugs, over-the-counter drugs and substances, prescription drugs, and cigarettes;
- f. Employment history including work skills and types and lengths of employment;
- g. Military history, if applicable;
- h. Current living situation including type of environment and nature of relationship with any room/house mates or family;
- i. Social and leisure time activities and skills;
- j. Communication skills;
- k. Ability to develop and maintain friendships;
- l. Involvement with or history of involvement with the law or criminal justice system;
- m. Guardianship, if applicable;
- n. Other legal documents; and
- o. A summary and evaluation of items in a. through n. that will be used to develop the ISP; and

(4) Information for children, including:

- a. A developmental and social history;
- b. An evaluation of the family situation, and, if applicable, school information;
- c. A summary of family support needs and involvement with other social service agencies; and
- d. Other portions of He-M 408.06(b) as applicable.

(c) The clinical data base shall be updated at least annually to:

- (1) Reflect the client's current diagnosis, symptomatology, and functional impairments; and
- (2) Document the client's need for continued services.

He-M 408.07 Physician Orders.

(a) A complete list of all ordered medications, laboratory testing, and, when applicable, dietary and other client specific orders shall be maintained in the clinical record on the physician's order sheet.

(b) Physician's order sheets or progress notes shall specify, at a minimum:

- (1) Client allergies;
- (2) Medication name;
- (3) Medication dosage;
- (4) Route of medication administration;
- (5) Medication frequency;
- (6) Medication start and stop dates; and
- (7) Whether or not the client has the cognitive ability to self-administer or control access to their medications, or both.

(c) At a minimum, a copy of each medication prescription shall be maintained in the clinical record for clients who self-administer and control access to their own medications.

(d) Each time a medication is added or deleted or when a dosage is adjusted, the prescribing psychiatrist shall document the change, the reason for the change, and the client's ability to understand and follow the new orders.

He-M 408.08 Individual Service Plan.

(a) The ISP shall be developed by a team that includes, at a minimum, a physician and a person experienced in diagnosis and treatment of mental illness, both criteria may be satisfied by the same person, if appropriately qualified.

(b) Documentation of annual client service planning shall be kept in the clinical record.

(c) At a minimum, documentation shall include:

- (1) A review of the previous year's progress toward achieving goals;
- (2) Identification of any service gaps and overlaps;
- (3) Current functional problems related to the client's mental illness;
- (4) Justification of the need for continued services;
- (5) Client, family, or other participation in the process; and
- (6) Any proposed revisions, additions, or deletions to the ISP.

(d) The ISP shall serve as a link between the client's problems and functional deficits resulting from mental illness and the treatment and rehabilitation goals and objectives, and the services to be provided.

(e) The ISP shall be person-centered and written in a style and language that is understandable to the client and other non-professionals, insofar as is possible.

(f) Functional problems addressed shall be the result of the client's mental illness and, if applicable, substance abuse and be identified through a functional assessment of the client's skills, strengths, and needs in relation to the skills demanded by the particular environments in which the client wants or needs to function.

(g) The ISP shall address the following, as applicable to the client:

- (1) Activities of daily living and social skills required for community tenure;
- (2) Adaptation to normal occurrences and changes in the daily routine;
- (3) Treatment and illness self-management;
- (4) Alcohol and substance abuse or dependence, and
- (5) Concentration, task performance, and pace necessary for activities of daily living, work, school, or other structured activities.

(h) The ISP shall:

- (1) Include a recommendation concerning guardianship, when necessary;
- (2) Specify the desired outcomes in the form of numbered goals and measurable objectives;
- (3) List the specific medical and remedial services, therapies, and activities, to be used to achieve the desired outcome;
- (4) State the duration and frequency of each type of planned therapeutic session or encounter;
- (5) Specify the type of personnel that will be furnishing each service;
- (6) Specify the person responsible for implementation of the plan;
- (7) Identify frequency of reviews of progress toward meeting goals and objectives as outlined in He-M 401;
- (8) Specify the start and anticipated completion dates for each objective;
- (9) Identify discharge criteria; and
- (10) Include documentation of all participants, including the licensed practitioner of the healing arts who recommended the service.

(i) The ISP shall address proactive crisis intervention via a crisis plan as defined in He-M 401.

(j) For those clients whose plans indicate residential or supported housing services, plans shall include specific, measurable objectives to be achieved through the provision of these services.

(k) For those clients whose plans indicate employment or vocational services, an employment goal shall be indicated.

(l) The ISP shall be signed by a psychiatrist. The signature shall indicate agreement that services are in response to the client's specific needs unless otherwise stated.

(m) The ISP shall include objectives that are:

- (1) Observable;
- (2) Measurable; and
- (3) Descriptive of the desired level of function.

(n) For those clients who receive medication monitoring only, the quarterly service plan review shall indicate that a comprehensive review has occurred and that additional services are not currently warranted. If the review indicates a need for additional services, the client service planning process as outlined in He-M 401 shall be followed.

He-M 408.09 Documentation of Service Delivery and Outcomes.

(a) Progress notes maintained for each client shall document:

- (1) The service and therapeutic interventions provided;
- (2) The client's symptoms;
- (3) The client's response to the service;
- (4) The date and time the delivery of service began and the date and time that the delivery of service ended;
- (5) The relationship of the services to the treatment regimen described in the individual service plan;
- (6) The setting where the service was rendered;
- (7) Who rendered the service; and
- (8) Updates describing the client's progress.

(b) Progress notes shall be written for each:

- (1) Face-to-face encounter;
- (2) Emergency services contact;
- (3) Contact related to a crisis or change in status; and
- (4) Service that a client receives in an intensive partial and rehabilitative partial hospitalization program pursuant to He-M 426; and
- (5) Targeted case management service pursuant to He-M 426.

(c) Documentation shall not be altered or changed by erasure or masking, such as through the use of liquid correction fluid. Corrections shall be made by drawing a line through the mistake. All corrections shall be signed and dated by the person making the change.

He-M 408.10 Outcome Measures. Outcome measures shall be completed quarterly on each client determined eligible for state supported services and programs. The results of outcome measures shall become part of each client's record.

He-M 408.11 ISP Reviews.

(a) Timeframes identified in this section shall not eliminate more frequent reviews required by insurers or other agency or federal regulations.

(b) All clients shall have an ISP review held at least every 90 days.

(c) As documented in the progress note for the reporting quarter, quarterly reviews shall be based on a clinical review of the client's current status and progress, or lack thereof, in achieving the goals identified on the ISP.

(d) Documentation of the review shall include:

- (1) The specific goal(s) addressed during this quarter;
- (2) The client's progress toward achieving ISP goals and objectives;
- (3) Services received during the reporting quarter;
- (4) A statement as to whether the services are medically necessary;
- (5) Description of the client's current functional problems resulting from the mental illness;
- (6) A statement regarding the need for continued services;
- (7) Any other relevant information, including hospitalizations during the reporting period;
- (8) Changes in the ISP as a result of the clinical review;
- (9) The time period covered by the review;
- (10) The date of the documentation; and
- (11) The signature and title of the person documenting the review.

(e) The fourth quarterly review shall serve as the annual service planning process and ISP development per He-M 401.

(f) The fourth quarterly review shall include, in addition to the components listed in (d) above, documentation of the following:

- (1) Redetermination of the client's psychiatric diagnosis;
- (2) Reassessment of the client's medications;
- (3) Assessment of the client's ability to deal with the symptoms of his or her mental illness and access generic community resources;

- (4) Assessment of the need for additional services or revisions to the ISP;
- (5) Need for referral to other health care or social service providers;
- (6) A list of the participants in this final yearly review process; and
- (7) A description of the level of client participation, if any, in the review.

. (g) Within 30 days of the ISP being developed, the psychiatrist shall sign the ISP as indication of CMHP approval of the ISP and as indication that the services to be provided that are covered by medicaid are medically necessary.

He-M 408.12 Service Suspension and Termination Notes.

(a) Whenever a client has been suspended or terminated from a program or service, a note shall be entered into the clinical record and shall include the date and reason(s) for the suspension or termination and that this action was taken with the approval of the program director.

(b) All suspensions and terminations shall follow the procedures identified in He-M 401.

He-M 408.13 Discharge/Transfer Note.

(a) A discharge/transfer note shall be entered into the clinical record:

- (1) Within 15 days after a client's transfer from a program; and
- (2) Within 30 days after a client's discharge from the agency.

(b) The discharge/transfer note shall consist of a summary which includes, at a minimum:

- (1) The reasons for admission;
- (2) Progress made by the client while in the program;
- (3) The client's diagnosis;
- (4) The client's physical and mental status at time of discharge or transfer;
- (5) A brief service and medication history;
- (6) A listing of the client's current medication(s);
- (7) Treating clinicians' recommendations for further services and treatment including referrals, if indicated;
- (8) The reason(s) for discharge or transfer;
- (9) A statement that notification of the discharge or transfer was given to the consumer; and
- (10) The prognosis.

(c) Discharge or transfer notes shall be available to other service providers with the permission of the client.

(d) The death of a client shall be documented and include:

- (1) The cause of death, when known;
- (2) The date and time of death; and
- (3) Results of an autopsy, when available.

He-M 408.14 Confidentiality.

(a) Each agency and facility, other than state facilities, shall develop and implement a policy regarding the confidentiality, storage, and disposal of clinical records and the circumstances under which information may be released.

(b) Confidentiality policies shall conform with He-M 309.

(c) The client's written authorization for the release of information shall be maintained in the clinical record.

He-M 408.15 Waivers.

(a) A CMHP or community mental health provider may request a waiver of specific procedures outlined in this part, in writing, from the department.

(b) A request for a waiver shall include:

- (1) A specific reference to the section of the rule for which a waiver is being sought;
- (2) A full description of why a waiver is necessary; and
- (3) A full explanation of alternative provisions or procedures proposed by the CMHP or community mental health provider.

(c) No provision or procedure prescribed by statute shall be waived.

(d) A request for a waiver shall be granted after the commissioner or his or her designee determines that the alternative proposed by the CMHP or community mental health provider meets the objective or intent of the rule and:

- (1) Does not negatively impact the health or safety of recipients; and
- (2) Does not affect the quality of CMHP or community mental health provider services.

(e) Upon receipt of approval of a waiver request, the CMHP's or community mental health provider's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which the waiver was sought.

(f) Waivers shall be granted in writing for a specific duration not to exceed 5 years except as in (g) below.

(g) Those waivers which relate to the following shall be effective for the CMHP's or community mental health provider's current certification period only:

- (1) Fire safety; or

(2) Other issues relative to consumer health, safety or welfare that require periodic reassessment.

(h) A CMHP or community mental health provider may request a renewal of a waiver from the department. Such request shall be made at least 30 days prior to the expiration of a current waiver.

APPENDIX
IMPLEMENTED STATUTES

Rule Number	RSA/Federal Citation
He-M 408.01 -408.15	RSA 135-C:5, I, (e); 135-C:61, III